Final Report of the Chronic Weight Management Task Force

Recommendations for addressing the obesity and diabetes epidemic in Tennessee

This task force is reporting its findings and recommendations to the General Assembly in accordance with amended Tennessee Code Annotated, Title 3; Title 4; Title 56, Chapter 1, Part 1 and Title 63, relative to the chronic weight management task force.

September 2022

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INTRODUCTION

Obesity has long been recognized as a disease in the US that impacts children and adults. Obesity is a complex, multifactorial, common, serious, relapsing, and costly chronic disease that serves as a major risk factor for developing conditions such as heart disease, stroke, type 2 diabetes, renal disease, non-alcoholic steatohepatitis, and certain types of cancer. Throughout the pandemic, obesity has also been linked to increased hospitalizations, the need for mechanical ventilation, and death in persons with COVID-19.[1] Obesity disproportionally affects some ethnic and/or racial groups with non-Hispanic Black adults having the highest prevalence, followed by Hispanic adults. Estimates have shown that the annual medical cost for people who have obesity are on average 42% -75% higher than those of normal weight, with costs increasing significantly with the severity of obesity.[2]

Almost one in five children in the US have obesity and the risk of obesity is greater among adults who had obesity as children. Obesity is more prevalent among American Indian and/or Native Alaskan, non-Hispanic Black, and Hispanic children compared with White and Asian children in the United States, with Black children having the highest prevalence of risk factors for obesity.[3] Children and adolescents have experienced sharp increases in their rates of weight gain during the COVID-19 pandemic, especially school-aged children and those who already had obesity; now more than ever, children and families need support in achieving and maintaining optimal weight for health.[4]

Research in populations with diabetes, hypertension, and cardiovascular diseases has shown that a 5% decrease in weight results in clinically significant improvements such as reduction or remission in cardiac health and diabetes or metabolic disease.[5,6,7,8] Comprehensive care of the patient who suffers from obesity involves lifestyle modification including diet and exercise, along with behavioral and nutritional counseling, utilizing evaluation and collective remedies by healthcare specialist such as, registered dietitians, exercise physiologist and mental health providers. Anti-Obesity Medications, when added to lifestyle modification, can achieve greater weight loss than lifestyle modification alone and can result in 5% - 15% body weight reduction.[9,10,11,12,13] In more severe cases, bariatric surgery is an additional

[1] Obesity, Race/Ethnicity and COVID-19. Centers for Disease Control and Prevention. https://www.cdc.gov/obesity/data/obesity-and-covid-19.html#COVID19

[2] Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. Annual medical spending attributable to obesity: payer-and service-specific estimates. Health Aff (Millwood) 2009;28(5):w822–31.

[3] Isong IA, Rao SR, Bind MA, Avendaño M, Kawachi I, Richmond TK. Racial and Ethnic Disparities in Early Childhood Obesity. https://pubmed.ncbi.nlm.nih.gov/29269386/

[4] Longitudinal Trends in Body Mass Index Before and During the COVID-19 Pandemic Among Persons Aged 2–19 Years — United States, 2018–2020, Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/70/wr/mm7037a3.htm

[5] Biener AI, Decker SL. Medical care use and expenditures associated with adult obesity in the United States. JAMA. Jan 16, 2018;319(3):218. PMID: 29340665.

[6] Biener AI, Decker SL. Medical care use and expenditures associated with adult obesity in the United States. JAMA. Jan 16, 2018;319(3):218. PMID: 29340665.

[7] Douketis JD, Macie C, Thabane L, Williamson DF. Systematic review of long-term weight loss studies in obese adults: clinical significance and applicability to clinical practice. Int J Obes Relat Metab Disord. 2005;29:1153–1167.

[8] Douketis JD, Macie C, Thabane L, Williamson DF. Systematic review of long-term weight loss studies in obese adults: clinical significance and applicability to clinical practice. Int J Obes Relat Metab Disord. 2005;29:1153–1167.

[9] Jensen MD et al; American College of Cardiology/American Heart Association Task Force on Practice Guidelines; The Obesity Society. *Circulation*. 2014;24(25 suppl 2):S102-S138.

[10] Wilding JP et al. *N Engl J Med*. 2021;384(11):989.

[11] Courcoulas AP et al. *JAMA*. 2013;310(22):2416-2425.

[12] Berry MA et al. *Obes Surg*. 2018;28:649-655.

[13] Garvey WT et al; Reviewers of the AACE/ACE Obesity Clinical Practice Guidelines. *Endocr Pract*. 2016;22(suppl 3):1-203.

treatment option, when medically necessary. **It is critical to provide health care professionals with the options they need to effectively treat their patients suffering from the disease of obesity.**

Despite the high and escalating prevalence of obesity and obesity related comorbidities, there are significant gaps in access to care for this disease. These gaps exist in both the **prevention** and **treatment** of obesity. If this lack of access to care is not addressed, obesity will continue to negatively impact the physical and financial health of all Tennesseans (children, seniors, employees, employers, and state government).

TASK FORCE RECCOMENDATIONS

1. **Solidify the Tennessee State Group Insurance Program's obesity treatment coverages.**
    - **a.** The State Group Insurance Program currently provides **comprehensive** coverage for lifestyle modification programs (nutritional counseling, behavioral counseling, and dietitian services), anti-obesity medications, and bariatric surgical procedures. This is a tremendous example of how an employer or state government can provide access to obesity care.
    - **b.** The Task Force applauds the State Group Insurance Program for their commitment to their members suffering with obesity and encourages the Program to make this access to obesity care permanent.

2. **Anti-Obesity Medication coverage for all TennCare enrollees who qualify and meet medical criteria.**
    - **a.** TennCare provides access to anti-obesity medications for enrollees under the age of 21. The Task Force recognizes and appreciates this treatment option that TennCare makes available to those members.
    - **b.** However, this age restriction creates a gap in care. To fill this gap, the Task Force recommends that TennCare provide coverage of anti-obesity medications to all enrollees who qualify and meet specified TennCare medical criteria.[14]

3. **Pharmacists Collaborative Practice Agreements (CPA) to include weight management services.**
    a. Pharmacists in Tennessee can provide patient care services and activities pursuant to a collaborative pharmacy practice agreement under Public Chapter 832, Acts of 2014.[15] *"Collaborative pharmacy practice"* is the provision of patient care services through a valid, executed collaborative pharmacy practice agreement (CPPA) between one or more Tennessee-licensed pharmacists and one or more Tennessee-licensed prescribers. The CPPA can also be between one or more pharmacists and the chief medical officer, medical director, or a designated physician in an organized medical group. Pharmacists working in this capacity can initiate, modify or discontinue medications, order and review laboratory tests, make referrals to other medical providers, and serve as a conduit to increased specialized pharmacotherapy care between patients' normal primary care provider (PCP) appointments.

[14] https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/clinical-criteria/Anorexia%20Agents.pdf
[15] https://publications.tnsosfiles.com/acts/108/pub/pc0832.pdf

b. For those pharmacists practicing under a CPA, the Task Force recommends the incorporation of overweight/ obesity management, and the ability to prescribe anti-obesity medications.

4. **Align TennCare's coverage of bariatric surgical procedures with The American Society for Metabolic and Bariatric Surgery pediatric guidelines.[16]**
    a. TennCare provides coverage of bariatric surgical procedures to members over the age of 18. This is a critical treatment option, and the Task Force values TennCare's commitment to treating obesity.
    b. The Task Force recommends TennCare align its coverage of bariatric surgical procedures with The American Society for Metabolic and Bariatric Surgery pediatric guidelines.[16]

5. **Encourage & Incentivize Health Plans & Pharmacy Benefit Managers that bid for state business such as TennCare and The Tennessee State Group Insurance Program to provide coverage for Lifestyle Modification Programs, Anti-Obesity Medications, and Bariatric Surgical Procedures to all their commercial lines of business.**

6. **TennCare's coverage of existing Registered Dietitian Services and Mental Health Counseling should include those diagnosed with Obesity.**
    a. TennCare currently covers visits with Registered Dieticians for members diagnosed with diabetes and chronic kidney disease. These treatment services should be extended to members with a diagnosis of Obesity.
    b. TennCare covers Mental Health Counseling for enrollees suffering from anxiety and depression. Mental Health treatment should also be available to members with an obesity diagnosis.

7. **Include BMI in Quality Metrics – Primary Care Physicians incentivized to treat obesity.**
    a. Current physician quality metrics include A1c, lipid profile, and blood pressure.
    b. The Task Force recommends incentivizing primary care physicians in addressing obesity by including BMI in the quality metrics.
    c. The Task Force recommends for patients with BMI $\geq$30, patients should either be referred for nutritional or behavioral counseling or prescribed an anti-obesity medication, if patient meets medical criteria.

8. **Further evaluate opportunities to address prevention with a concentration in childhood obesity and early intervention in metabolic disease.**
    a. The Task Force recognizes the importance of early intervention and prevention, specifically in prenatal, infancy, pre-school, and school-age children.
    b. The Task Force recommends further evaluation in coordination with the Department of Education to consider health, wellness, and nutrition as critical components of our Tennessee educational system.

[16] https://asmbs.org/app/uploads/2018/08/PIIS155072891830145X-Pediatric-in-Press.pdf

The Task Force recommends the Tennessee General Assembly encourage Congress and CMS to eliminate barriers to coverage of FDA-approved anti-obesity medications in the Medicare Part-D program and allow Medicaid enrollees access to the full continuum of treatment options for obesity, including FDA-approved anti-obesity medications.

THE STATE OF OBESITY IN TENNESSEE

- Adults
  - 1,941,224 adults living with obesity[17,18]
  - 36.5% of TN adult population is suffering from obesity[18]
    - 47.5% of Blacks
    - 34.8% of Whites
    - 36.3% of Hispanics
    - 32.7% of Seniors
- Children
  - 20.8% of children ages 10-17 have obesity[19]
  - TN is ranked is ranked 6th out of the 50 states and D.C. for childhood obesity rate[19]
- Obesity impacts the overall health of Tennesseans
  - Obesity is associate with more than 60 comorbidities[20]
    - 13.8% Adult diabetes rate[21]
    - 39.3% Adult hypertension rate[22]
    - 36.2% Adult high cholesterol rate[23]

NATIONAL OBESITY STATISTICS

- By 2030, nearly 1 in 2 adults within the United States are projected to have obesity. (BMI ≥ 30 kg/m^2)[24, 25]

[17] U.S. Census Bureau. 2019: ACS 1-year estimates subject tables. https://data.census.gov/cedsci/table?q=United%20States&t=Age%20and%20Sex&g=0100000US.04000.001&y=2019&tid=ACSST1Y2019.S0101&hidePreview=true&moe=false. Accessed July 20, 2021.

[18] Nutrition, physical activity, and obesity: data trends and maps. Centers for Disease Control and Prevention website. https://nccd.cdc.gov/dnpao_dtm/rdPage.aspx?rdReport=DNPAO_DTM.ExploreByTopic&islClass=OWS&islTopic=OWS1&go=GO. Accessed September 9, 2021

[19] State of Childhood Obesity. https://stateofchildhoodobesity.org/state-data/?state=tn

[20] What is obesity? Obesity Medicine Association website. https://obesitymedicine.org/what-is-obesity/. Accessed September 9, 2021.

[21] BRFSS prevalence trends & data: diabetes. Centers for Disease Control and Prevention website. https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocationType=StatesAndMMSA&islClass=CLASS10&islTopic=TOPIC31&islYear=2019&rdRnd=7481. Accessed September 9, 2021.

[22] BRFSS prevalence & trends data: high blood pressure. Centers for Disease Control and Prevention website. https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocationType=StatesAndMMSA&islClass=CLASS10&islTopic=TOPIC31&islYear=2019&rdRnd=74815. September 7, 2021.

[23] BRFSS prevalence & trends data: cholesterol high. Centers for Disease Control and Prevention website. https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocationType=StatesAndMMSA&islClass=CLASS02&islTopic=TOPIC12 &islYear=2019&rdRnd=19278. Accessed September 9, 2021.

[24] Ward ZJ, Bleich SN, Cradock AL, et al. Projected U.S. state-level prevalence of adult obesity and severe obesity. New England Journal of Med. 2019;381(25):2440-2450.

[25] Ramasamy A, Laliberté F, Aktavoukian SA, et al. Direct and indirect cost of obesity among the privately insured in the United States. JOEM. 2019;61(11):877-886.

- By 2030, nearly 1 in 4 adults within the United States are projected to have Class II or Class III obesity. (BMI ≥ 35 kg/m^2)[24,25]
- Employees with obesity incur more than 2.5x increase in cost vs employees with normal weight. *(Includes medical, pharmacy, sick days, disability, absenteeism, lower productivity, and workers' compensation costs. Cost increase depends on class (severity) of obesity.)* $14,341 to $28,321 cost per employee with obesity per year. *(Range is based on class (severity) of obesity).*[25]
- Absence due to illness or injury is increased 128% for employees with obesity: 3 additional days per year. $271 to $542 in annual productivity loss per employee with obesity.[26]
- An APA Stress in America survey conducted in February 2021 revealed an average weight gain of 29 lbs. in 42% of the population due to the pandemic.[27]

MILESTONES IN REGARDING OBESITY AS A DISEASE[28]

- 1998
    - The National Institutes of Health published Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults that stated, "Obesity is a complex multifactorial chronic disease."[29]
- 2002
    - The Internal Revenue Service issued a ruling that expenses for obesity treatment would qualify as deductible medical expenses.[30]
    - The Social Security Administration (SSA) published an evaluation of obesity stating that "Obesity is a complex, chronic disease characterized by excessive accumulation of body fat."[31] This determination explicitly stated that obesity is a valid medical source of impairment for the purpose of evaluating Social Security disability claims.
- 2004
    - CMS removed language stating that "obesity is not an illness" from its Coverage Issues Manual.[32] Although this action did not include a specific determination that obesity is a disease, it removed a significant obstacle to further progress and coverage for obesity-related medical services.

[25] Ramasamy A, Laliberté F, Aktavoukian SA, et al. Direct and indirect cost of obesity among the privately insured in the United States. JOEM. 2019;61(11):877-886.
[26] Cawley J, Biener A, Meyerhoefer C, et al. Job absenteeism costs of obesity in the United States: national and state-level estimates. J Occup Environ Med. 2021;63(7):565-573.
[27] https://www.apa.org/monitor/2021/07/extra-weight-covid#:~:text=For%20many%20people%2C%20those%20outward,average%20gain%20of%2029%20pounds
[28] Regarding Obesity as a Disease: Evolving Policies and Their Implications: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4988332/
[29] National Heart, Lung, and Blood Institute. Clinical Guidelines on the Identification, Evaluation, Treatment of Overweight and Obesity in Adults. (NIH publication 98-4083).The Evidence Report. 1998 Sep; http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf.
[30] Anderson C. Obesity Is Tax Deductible. CBSnews.com. 2002 Available at: http://www.cbsnews.com/news/obesity-is-tax-deductible/. Accessed November 20, 2015.
[31] SSA.gov. Social Security Administration Program Operations Manual (POMS) - DI 24570.001 Evaluation of Obesity. 2002 Available at: https://secure.ssa.gov/poms.nsf/lnx/0424570001. Accessed November 20, 2015.
[32] Tillman K. National Coverage Analysis (NCA) Tracking Sheet for Obesity as an Illness (CAG-00108N) CMS.gov. 2004 Available at: https://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=57&TAId=23&IsPopup=y&bc=AAAAAAAAAgAAAA%3D%3D&. Accessed November 20, 2015.

- 2006
    - CMS issued a National Coverage Determination providing coverage for bariatric surgery under Medicare, a decision that followed as a natural consequence of the agency's 2004 reassessment of obesity.[33]
- 2008
    - The Obesity Society published a white paper on evidence and arguments for obesity as a disease.[34]
- 2012
    - The American Association of Clinical Endocrinologists publishes a position that obesity is a disease.[34]
- 2013
    - The American Medical Association resolved at its annual House of Delegates meeting to "recognize obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention."[35] Though this resolution has no legal standing, the AMA has stated that "recognizing obesity as a disease will help change the way the medical community tackles this complex issue."
- 2014
    - The U.S. Office of Personnel Management ((OPM) serves as the chief human resources agency and personnel policy manager for the Federal Government) issued Carrier Letter 2014-04[36] clarifying that it is not permissible to exclude weight loss drugs from Federal Employees Health Benefits (FEHB) coverage on the basis that obesity is a "lifestyle" condition and not a medical one or that obesity treatment is "cosmetic."
- 2016
    - A joint statement by international diabetes organizations support inclusion of bariatric or "metabolic" surgery as an intervention to treating type 2 diabetes.[37]
- 2022
    - OPM restates in Carrier Letter 2022-03[38] that FEHB Carriers are not allowed to exclude anti-obesity medications from coverage based on a benefit exclusion or a carve out. FEHB Carriers must have adequate coverage of FDA approved anti-obesity medications on the formulary to meet patient needs.

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[33] CMS issued a National Coverage Determination providing coverage for bariatric surgery under Medicare, a decision that followed as a natural consequence of the agency's 2004 reassessment of obesity.
[34] Mechanick JI, Garber AJ, Handelsman Y, Garvey WT. American Association of Clinical Endocrinologists' position statement on obesity and obesity medicine. Endocr Pract. 2012;18(5):642–8.
[35] Pollack A. AMA Recognizes Obesity as a Disease. NYTimes.com. 2013 Available at: http://nyti.ms/1Guko03. Accessed November 20, 2015.
[36] https://www.opm.gov/healthcare-insurance/healthcare/carriers/2014/2014-04.pdf
[37] https://diabetesjournals.org/care/article/39/6/861/29305/Metabolic-Surgery-in-the-Treatment-Algorithm-for
[38] https://www.opm.gov/healthcare-insurance/healthcare/carriers/2022/2022-03.pdf

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RESOURCES

https://www.jandonline.org/article/S2212-2672(20)30970-9/fulltext
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6473916/
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